COLORADO
Department of Health Care Policy & Financing

MINUTES OF THE MEDICAID PROVIDER RATE REVIEW ADVISORY COMMITTEE (MPRRAC)

The Colorado Department of Health Care
Policy and Financing
303 East 17th Avenue, 7th Floor Conference Room

Friday, September 21, 2018
9:00 AM – 2:00 PM

Audio from the full meeting can be accessed via this link.
This document contains a high-level summary of discussions during the meeting.

1. MPRRAC Members Present (in person or via phone)

Rebecca Craig, Lisa Foster, Gretchen McGinnis, Dixie Melton, Wilson Pace, Jeff Perkins, Tom Rose, David Smart, Murray Willis, Jody Wright, Carol Morrow, Sue Flynn, Rob Deherrera, Art Schut

2. Agenda Review

Committee members approved meeting minutes from July 20, 2018. Gretchen Hammer, Medicaid Director, announced her departure from the Department on October 12, 2018. Bill Heller, Benefits and Services Division Director, will replace Gretchen as the senior executive representative at future MPRRAC meetings. Committee members thanked Gretchen for her support of the committee and the process.

3. Stakeholder Feedback and Committee Discussion

Lisa Foster, chair, reviewed the guiding principles of the MPRRAC ahead of making recommendations. The committee's guiding principles include:

- "Don't reinvent the wheel"; if an appropriate rate benchmark or rate setting methodology exists, try to use it.
- Support rates and methodologies that encourage care to be delivered in the least restrictive and least costly environment.
- Develop methodologies to account for the differences in delivering services in geographically different settings, especially rural settings.
- Rates and methodologies should attempt to cover the direct costs of goods and supplies for providers.

The committee decided to discuss each recommendation and to wait until discussion concludes to finalize recommendations.

Evaluation & Management and Primary Care

The committee was reminded of its preliminary recommendation from the July 20th meeting:

> Except for policy-specific carve outs, the Department should conduct a budget-neutral rebalancing of rates below 85% and above 100% of the benchmark.

Kimberley Smith, Compliance and Stakeholder Relations Unit Manager, shared that the Department supports the general concept of the recommendation; however, the Department may add additional nuance to its recommendation to address, for example, the impact on the Alternative Payment Methodology. She also stated that instead of rebalancing all rates below 85% and above 100% of the benchmark, the Department may choose to look at all rates under 85% and above 100% of the benchmark and conduct a thorough rate setting process to set those rates appropriately in a budget neutral manner, within the spirit of the recommendation.

The committee did not discuss further. No stakeholders provided comment.

Radiology Services and Other Physician Services and Surgeries

The committee was reminded of its preliminary recommendations from the July 20th meeting:

> Radiology: Except for policy-specific carve outs, the Department should conduct a budget-neutral rebalancing of rates below 80% and above 100% of the benchmark.
>
> Physician Services and Surgeries: To the extent possible, the Department should perform a budget-neutral rebalancing of rates below 80% and above 100% of the benchmark (except for policy-specific carve outs), then the Department should seek necessary funding from the legislature for additional adjustments.

Jeff Perkins, committee member, suggested the committee consider prefacing all recommendations with a statement that the committee believes the following recommendations should be pursued in a budget neutral manner where possible; however, when additional funding is necessary we recommend the Department seek additional funding. Wilson Pace, vice-chair, noted that, for radiology and physician services and surgeries the benchmark comparison percentages were significantly under 80%, which is why the committee chose in its preliminary recommendations to specifically suggest the Department seek additional funding for these specific service groupings.

Wilson Pace asked the committee if its recommendations should also specify where services were compared to other Medicaid states, rather than Medicare, for the benefit of those less familiar with the process. Kimberley Smith stated this would be clearly stated in the November 1st report. Carol Marrow stated that it would be beneficial to make this point several times within the report.

Kimberley Smith shared that the Department supports the general concept of recommendation to rebalance rates below 80% and above 100% in a budget neutral manner.

The committee did not discuss further. No stakeholders provided comment.

Maternity Services

The committee was reminded of its preliminary recommendations from the July 20th meeting:

> The Department should seek funding from the legislature to bring maternity service rates to 90% of the benchmark.

Kimberley Smith shared that the Department notes the rates are below 80% of the comparison benchmark; however, the Department does not see an impact on access and the Department does not plan to recommend an increase to maternity service rates at this time. The Department does, however, plan to think about maternity services specifically when moving forward with plans to explore quality improvement and value-based payment and how, for example, maternity services can be incorporated in the Hospital Quality Incentive Program over the next 12 to 18 months. Gretchen Hammer, Medicaid Director, noted we pay for approximately 42% of the births in the state of Colorado, so when we are directed to make sure we are doing things like paying for services in ways that increase value, we see maternity services as a core opportunity to do that. She noted that there is further opportunity to explore value-based payment through the Hospital Transformation program while also looking at underlying costs.

Wilson Pace and Jeff Perkins noted that maternity services aren't something that women have a choice around seeking care for. Wilson noted that, while women may have access, poor care can lead to costly health outcomes. Wilson also noted that the access map in the May analysis report suggested access in that region was light in the south west corner of the state. Dixie Melton, committee member, noted a large OBGYN practice of roughly ten providers in Durango and that there are no providers in Archuleta county.

Jeff Perkins noted that the rates under review are not hospital payments. Jeremy Tipton, Rates Unit Manager, noted they are all physician payment codes, regardless of place of service, but they are not hospital payments.

Jeff Perkins asked the committee if they should consider lowering the amount by which they recommended rates be increased (90% of the benchmark) within their preliminary recommendation. Lisa Foster, seconded that. Wilson Pace then reminded the committee that the comparison is the Medicaid, not Medicare (i.e. the committee, in suggesting that rates be increased to 90% of the benchmark, is not recommending that rates be increased to 90% of Medicare). Kimberley Smith noted Jeremy Tipton's earlier comment that, although the Department did not compare its rates to Medicare, Medicare rates, in this instance, are similar to the Medicaid rates used in the comparison.

The committee ultimately chose not to reduce the number within their preliminary recommendation. No stakeholders provided comment.

Physical and Occupational Therapy Services

The committee was reminded of its preliminary recommendations from the July 20th meeting:

The Department should:

1. Except for policy-specific carveouts, the Department should conduct a budget-neutral rebalancing of rates below 80% and above 100% of the benchmark.
2. For the deconsolidated physical therapy evaluation code (formerly 97001, currently 97161, 97162, and 97163), the Department should:
    a. Keep 97161 at the current rate;
    b. Adjust 97162 to 100% of the Medicare benchmark; and
    c. Adjust 97163 to $100.
3. Until clearer national coding guidelines are developed, Colorado Medicaid should adopt clear, time-based definitions for the deconsolidated physical therapy codes.

Kimberley Smith shared that the Department supports the general concept of recommendation #1 to rebalance rates below 80% and above 100% in a budget neutral manner. Regarding recommendation #2, Kimberley noted previous stakeholder comment that there has been

confusion regarding when to bill newly deconsolidated codes 97161, 97162, and 97163.[1] The Department stands by its rate setting process and believes, to the extent that confusion exists, the solution is one of education and not to increase the rates for 97162 and 97163. Kimberley pointed out that an increase of 97162 to 100% of the Medicare benchmark would be a 23% increase over reimbursement that providers received prior to the deconsolidation of the code. Likewise, an increase of 97163 to $100 would represent a 42% increase over the reimbursement prior to deconsolidation. Regarding recommendations #2 and #3, Kimberley stated that the Department believes it is the responsibility of providers to code correctly and avail themselves of professional resources to help them do that. She pointed out that the American Physical Therapy Association worked with the AMA to create the definitions for these three codes and that, on the APTA website, they are described as low complexity, medium complexity and high complexity codes (not time-based codes) and provide tools to help providers bill appropriately.

Most discussion focused on recommendations #2 and #3 above, regarding the deconsolidation of the physical therapy evaluation code 97001.

Jeff Perkins and Sue Flynn, committee members, stated that they do not believe they intended, in July, to recommend at 23% increase to reimbursement for code 97162 but, rather, to return it to the original reimbursement rate, and that the committee did intend for the rate for 97163 to be higher than before, and the rate for 97161 to be lower. Sue Flynn asked for clarification, noting that in past discussions Medicaid has talked about these codes being time-based. Gretchen Hammer, Medicaid Director, stated that the Department has clarified multiple times that this is primarily a complexity based code. Kimberley Smith added that time is included in the CPT code definition at the end of the definition; it reads “typically X number of minutes”, but that it is really up to the provider to select the appropriate codes and include supporting documentation in the medical record.

Wilson Pace noted that, from the physician perspective, the manner in which the Department set rates when it deconsolidated code 97001 into the three codes above was not appropriate; it was not budget neutral. He also stated that the CPT code definitions are not clear about how providers should gauge complexity. Gretchen Hammer, Medicaid Director, asked if the committee wanted this perspective reflected in the November report. Sue and Jeff said yes. Wilson Pace noted that the meeting minutes are open to the public and the committee may want to be careful about the wording of their recommendation in the report. Gretchen McGinnis, committee member, stated that, where the committee disagrees, it needs to own that and state that, in a respectful way.

Betsy Murray, representing the American Physical Therapy Association Colorado Chapter, stated that she appreciates the committee’s efforts to increase reimbursement for codes 97162 and 97163. However, those she represents still feel the reimbursement rate for 97121 (of $29.05) is too low and they will be making efforts to lobby for an increase of reimbursement for that code (to $68.08). She also recommended that re-evaluation code 97002 be increased to $38.50 and 97164 be increased to $57.61. Betsy also stated that, since the July MPRRAC meeting, she has heard from several providers who are just now realizing that reimbursement for lower complexity evaluations has decreased and are now re-evaluating their bottom-line.

Jeff Perkins noted that the stakeholder recommendation to increase re-evaluation codes would be covered under the committee’s first recommendation, which asks the Department to

[1] For reference, beginning January 2017, the physical therapy evaluation procedure code (97001) was deleted and replaced with three codes that contain more specific descriptions based on complexity (97161, 97162, 97163). Rates for 97161 and 97162 were decreased accordingly; the rate for 97163 was increased.

rebalance rates below 80% of the Medicare benchmark. Sue Flynn, a committee member who provides physical and occupational therapy, stated that code 97161 is intended to be a brief evaluation and does not think it should be paid at $68.08 and any increase should be slight. Carol Marrow, committee member, stated that, if 97161 is too low, it may drive providers to bill the higher rate code. Jeff Perkins stated that that is always a possibility but that rates should be appropriately set. Sue Flynn said that the guidance she gives to providers in her clinic is that they need to bill the appropriate code.

Gretchen McGinnis suggested that the MPRRAC may not want to set the precedent of being prescriptive regarding amounts for specific rates, which would be a first for the committee.

The Committee agreed and moved away from recommending specific rates and towards a recommendation that would maintain overall reimbursement for the three codes at levels similar to reimbursement for code 97001 in FY16-17, while recognizing that all three should not be reimbursed at the same rate.

The committee changed their recommendations to the following:

The Department should:

1. Conduct a budget-neutral rebalancing of rates below 80% and above 100% of the benchmark.
2. For the deconsolidated physical therapy evaluation code (formerly 97001, currently 97161, 97162, and 97163), the Department should adjust the rates for each such that the aggregate of the three new codes is reimbursed similarly to code 97001 in FY16-17. For example, to consider reimbursing 97161 at the current rate, increasing 97162 reimbursement to the 97001 rate in FY16-17, and increasing the reimbursement for 97163 proportionately.
3. Until clearer national coding guidelines are developed, Colorado Medicaid should adopt clear, time-based definitions for the deconsolidated physical therapy codes.

The committee voted on the change to recommendation #2; twelve approved, none disapproved, none abstained.

Betsy Murray stated that the American Physical Therapy Association Colorado Chapter would like to be included in any Department discussions to reset rates for the codes mentioned above.

Dental Services

Kimberley Smith provided the committee with an updated Dental Services Scatterplot similar to those developed for other services in Appendix F of the Rate Review Analysis Report and reminded the committee that the 2017 Dental Services Annual Report had been published since the last MPRRAC meeting and contained information relevant to evaluating access to services.

Carol Marrow, a committee member who provides dental services, stated that, while Colorado's reimbursement rates are higher than most other Medicaid states, the program is exponentially more successful than in other states.

Jennifer Goodrum, Director of Government Relations at the Colorado Dental Association, stated: that the adult dental benefit is new to Colorado Medicaid. Rates for these services were recently and thoughtfully set, the program is working well, and more time should likely pass to collect better trend data before considering rate reductions; that, while rates appear high compared to the benchmarks, the benchmark comparators are other Medicaid states (not Medicare), that many Medicaid states do not provide adult dental service coverage, and that those that do often

do not reimburse adequately; that the legislature through its appropriations process has chosen to incentivize certain services, such as prevention, basic fillings, and extractions, and that these decisions have helped increase access to dental services across the state; and that, while client utilization may appear low, low utilization of dental services is a national trend across all payers and Colorado Medicaid client and provider participation rates are actually among the highest in the nation.

Bill Heller, noted that, in the first year of the adult dental benefit, the Department reduced ER costs by $10 million and affirmed that the American Dental Association and other states look to Colorado as a leader in the Medicaid dental space.

The committee determined no recommendation was needed and offered a general statement that dental services activities are going well and the committee has no recommendations for changing Dental rates.

4. Next Steps

At this point in the meeting, a quorum of committee members was no longer present to take a final vote. The committee determined to take a final vote on all recommendations electronically post-meeting. See results further below.

Wilson Pace recommended the following over-arching recommendations for the group to consider:

> The optimal goal for service payments is parity with Medicare or other appropriate benchmarks based on the services being provided; however, the following recommendations recognize that goal may not be achievable in the short term.
>
> A general committee policy recommendation is that any changes in payment rates should take into account policy-specific rate carve-outs for codes that are paid at higher than benchmark rates.

The committee nominated Rebecca Craig as vice-chair of the committee for year four of the rate review process. Gretchen Hammer noted that original committee appointments were for four years, so the vice-chair would not become the chair in year five. Committee members asked the Department for clarity on exactly when their terms end and the Department committed to following up.

Lisa Foster asked how the new members of the Joint Budget Committee will be educated about the MPRRAC's past rate review recommendations. Gretchen Hammer committed to educating the four new members on this process and, in doing so, will not just focus on this year's rate recommendation report recommendations.

The committee did not set a meeting schedule for year four in part because of the uncertainty around when committee member terms may end. Kimberley committed to sending out possible meeting dates for November and January for vote.

5. Meeting Adjourned

6. Recommendations

As of 10/18/18, the following committee members voted via electronic survey to confirm Rebecca Craig as vice-chair of the committee for year four of the rate review process, and upon the MPRRAC's final recommendations to the Department for year three services: Art Schut, Barbara Wilkins-Crowder,

David Smart, Dixie Melton, Gretchen McGinnis, Jeff Perkins, Jody Wright, Lisa Foster, Murray Willis, Rebecca Craig, Rob DeHerrera, Sue Flynn, Tia Sauceda, Tom Rose, and Wilson Pace.

General Recommendations

The optimal goal for service payments is parity with Medicare or other appropriate benchmarks based on the services being provided; however, the following recommendations recognize that goal may not be achievable in the short term.

(Votes for: 15; Votes against: 0; Abstain: 0)

A general committee policy recommendation is that any changes in payment rates should take into account policy-specific rates carve-outs for codes that are paid at higher than benchmark rates.

(Votes for: 15; Votes against: 0; Abstain: 0)

Evaluation & Management and Primary Care Recommendation

The Department should conduct a budget-neutral rebalancing of rates below 85% and above 100% of the benchmark.

(Votes for: 14; Votes against: 0; Abstain: 1)[2]

Radiology Recommendation

The Department should conduct a budget-neutral rebalancing of rates below 80% and above 100% of the benchmark.

(Votes for: 15; Votes against: 0; Abstain: 0)

Physical and Occupational Therapy Recommendation

Regarding physical and occupational therapy services, the MPRRAC recommended:

1. The Department should conduct a budget-neutral rebalancing of rates below 80% and above 100% of the benchmark.

2. For the deconsolidated physical therapy evaluation code (formerly 97001, currently 97161, 97162, and 97163), the Department should adjust the rates for each, such that the aggregate of the three new codes is reimbursed similarly to code 97001 in FY16-17.

   For example, consider reimbursing 97161 at the current rate, increasing 97162 reimbursement to the 97001 rate in FY16-17, and increasing the reimbursement for 97163 proportionately.

3. Until clearer national coding guidelines are developed, Colorado Medicaid should adopt clear, time-based definitions for the deconsolidated physical therapy codes.

(Votes for: 13; Votes against: 0; Abstain: 1)[3]

Maternity Recommendation

The Department should seek funding from the legislature to bring maternity service rates to 90% of the benchmark.

(Votes for: 15; Votes against: 0; Abstain: 0)

Physician Services and Surgeries Recommendation

[2] Murray Willis abstained.

[3] Murray Willis abstained. Gretchen McGinnis did not vote on this recommendation.

Regarding surgeries, the MPRRAC recommended:

1. The aggregate expenditures for these services is significantly below the 80% benchmark goal, thus the committee recommends that the Department should seek additional funding to increase overall spending in this area.

2. Furthermore, the Department should perform a budget-neutral rebalancing of rates below 80% and above 100% of the benchmark.

(Votes for: 15; Votes against: 0; Abstain: 0)

Dental Recommendation

None. Dental service activities are going well and the committee has no recommendations for changing Dental rates.

(Votes for: 15; Votes against: 0; Abstain: 0)